. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9768 CERTIFICATE OF DEATH

Reg. Dist. No. 09741

THIS IS A PERMANENT RECORD
PLEASE TYPE, OR PRINT IN PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN
Every item of information must be carefully supplied. Physicians: please write the causes of death clearly and legibly.
THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH

1. NAME OF DECEASED (Type or Print): Constantina Amentis

2. DATE OF DEATH: Sept 9 1958

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location): 700 Redbird Ave Baltimore 25

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 Redbird Ave 1

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 20 1871
9. AGE (In years last birthday): 87
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10B. KIND OF BUSINESS OR INDUSTRY: housework
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Victoria Zillis ADDRESS: 3504 Shenandoah Ave

CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Arteriosclerotic C.V.D — 10 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II
19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20. AUTOPSY? YES ☐ NO ☐

22. I certify that (I) (this hospital) attended the deceased from June 12 1958 to Sept 9 1958, that (I) (we) last saw the deceased alive on Sept 2 1958, and that in (my) (our) opinion death occurred at 10 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Paul Schnell M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
23B. ADDRESS: 801 Annapolis Rd
23C. DATE SIGNED: 9/10/58

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-12-58
24C. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd Balto Md

DATE RECEIVED BY REGISTRAR: SEP 11 1958
REGISTRAR'S SIGNATURE: ~~Huntington Williams M.D.~~ Arthur L. Travis
25. FUNERAL DIRECTOR: Charles J. Kachanuskas ADDRESS: 637 Wash. Blvd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9769

Reg. Dist. No. 09742

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magothy Beach (Pasadena RFD)
c. LENGTH OF STAY IN 1b: 3 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Riverside Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Magothy Beach (Pasadena RFD)
d. STREET ADDRESS: 1 Riverside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: John Bauer — Last: Jr.

4. DATE OF DEATH: Month: SEPT. — Day: 24 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 4, 1928

9. AGE (In years last birthday): 30 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Halls Motor Trans.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Francis J. Bauer, Jr.

14. MOTHER'S MAIDEN NAME: Margaret C. Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): '46 - '47

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Marcia Bauer — Address: 1909 Maisel St. Balto. #30, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1½ YRS.

199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CACHEXIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 30, 1957, to SEPT 24, 1958, that I last saw the deceased alive on SEPT 24, 1958, and that death occurred at 11 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr. M.D.
ADDRESS (Street, city or town, state): Mountain Rd. Pasadena, Md.
DATE SIGNED: 9/24/58

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR. MD — PASADENA, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 29, 1958
22c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l. Cem.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 29 58
24b. REGISTRAR'S SIGNATURE: Clinton L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09743

CERTIFICATE OF DEATH

9770 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lime Kiln 10X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐?

3. NAME OF DECEASED (Type or print): First Mary; Middle; Last Bell

4. DATE OF DEATH: Month Sept; Day 3; Year 1958

5. SEX: Female

6. COLOR OR RACE: n negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1905 ~~1905~~

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Bell

14. MOTHER'S MAIDEN NAME: Mariah Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia and Hypostetic pneumonia — INTERVAL BETWEEN ONSET AND DEATH

442X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebrel Thrombosis

DUE TO

(c) Hypertensive Arteriosclerotic cardiovascular-renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Decubitus ~~ulcer~~ ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State) 0

21. I certify that I attended the deceased from October 18, 1947 to Sept. 3, 1958 that I last saw the deceased alive on September 3, 1958 and that death occurred at 3:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel Mc Henry Mapp M.D.

ADDRESS (Street, city or town, state): Crownsville State Hospital

DATE SIGNED: Sept. 3, 1958

PHYSICIAN'S NAME (Type): Lionel Mc Henry Mapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-6-58

22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW

22d. LOCATION (City, town, or county) (State): Frederick Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III ADDRESS: Frederick-Md

24a. REC'D BY REGISTRAR DATE SEP 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9771

09744 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION: 414 Cleveland Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Linthicum Heights
d. STREET ADDRESS: 414 Cleveland Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MIRIAM Middle FRANCE Last BELL

4. DATE OF DEATH: Month Sept. Day 25, Year 1958

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 12, 1905
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): File Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Westinghouse Corp.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Yeatman
14. MOTHER'S MAIDEN NAME: Ella May -- (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-05-9577
17. INFORMANT: Mr. Edward H. Bell - 414 Cleveland Rd. Address: Linthicum Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Lung, Bone — INTERVAL BETWEEN ONSET AND DEATH: 12 mo.
153.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): (Operated 7/25/58 Inoperable)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19__, to 9/25/58, 19____, that I last saw the deceased alive on 9/25/58, 19____, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. M.D. ADDRESS (Street, city or town, state): 2024 W Nicholas Rd. DATE SIGNED: 9/25/58
PHYSICIAN'S NAME (Type): Linthicum

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/29/58
22c. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons - Balto 17, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE: SEP 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09745

Reg. Dist. No. 9772

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b: Few instants.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sun Ray's Drug Store

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 4546 N.Rogers Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Arnold Middle Maccabbi Last Bick

4. DATE OF DEATH: Month September Day 22rd. Year 19 58

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/6/1900
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver for a Clothes Cleaner Org.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Vienna, Austria, Europe.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Julius Bick
14. MOTHER'S MAIDEN NAME: ? ? Hein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address 826 Fairoak Ave. Mrs. Dr. Max Herzberg, P.O.Hyatsville, M.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. 9/22/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 23/58.
22c. NAME OF CEMETERY OR CREMATORY: Shomre Mishmeres
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: L. Levinson & Bros Inc
ADDRESS: 1124-26 W. North Ave
24a. REC'D BY REGISTRAR DATE: SEP 24 '58
24b. REGISTRAR'S SIGNATURE: Clifton L. Mears

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME $M 2/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3773 CERTIFICATE OF DEATH

Reg. Dist. No. 09746

1. PLACE OF DEATH — County: Anne Arundel County — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Calvert
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4y 11m 9d
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forrest Park
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital
d. STREET ADDRESS: 3700 Block Edgerton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oliver — Middle: — Last: Booth
4. DATE OF DEATH: Month: 9 — Day: 29 — Year: 1958
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4/11/89
9. AGE (In years last birthday): 69 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John William Booth
14. MOTHER'S MAIDEN NAME: Elizabeth Giles
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ---
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardiovascular Disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]
20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m — 19---
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/10 1953 to 9/29 1958, that I last saw the deceased alive on 9/29 1958, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED:
PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): 10-3-58
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Nat. Hospl
22d. LOCATION (City, town, or county) (State): Sandy Land Calvert, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [illegible] Funeral Service
24a. REC'D BY REGISTRAR DATE: OCT 6 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9774 CERTIFICATE OF DEATH

Reg. Dist. No. 09747

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1y 4m 20d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1124 Mosher Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Morgan — Middle: — Last: Bowser

4. DATE OF DEATH: Month: 9 — Day: 15 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/10/04

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Ellis Bowser

14. MOTHER'S MAIDEN NAME: Amanda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-01-1089

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Syphilitic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m: ------ 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 10/19/57, 19__, to 9/14/, 19 58, that I last saw the deceased alive on 9/14/, 19 58, and that death occurred at 10:45P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leon W. Whitt, M.D.

ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.

DATE SIGNED: 9/15/58

PHYSICIAN'S NAME (Type): Leon W. Whitt, M. D.

Crownsville State Hospital, Md. 9/15/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/18/58

22c. NAME OF CEMETERY OR CREMATORY: Mount Calvary

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Elroy O Wilson

ADDRESS:

24a. REC'D BY REGISTRAR DATE: 9 16 58

24b. REGISTRAR'S SIGNATURE: Esther E Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09748

9775 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 10y 9m 25d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21214
d. STREET ADDRESS: 631 Archer Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert — Middle — Last Bracey

4. DATE OF DEATH: Month 9 — Day 30 — Year 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1876 ?

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Needam Bracey

14. MOTHER'S MAIDEN NAME: Martha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Myocardial Scarring

DUE TO

(c): Coronary Arteriosclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour a. m. p. m. Month ----- Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State): ---------

21. I certify that I attended the deceased from 12/05, 19 47, to 9/30, 19 58, that I lost saw the deceased alive on 9/30, 19 58, and that death occurred at ____ M, from the causes and on the date stated above

ACTUAL SIGNATURE: L. Benedict M.D. — M.D.

ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/30/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. 9/30/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/1/58

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Chas J Cooper & Co — ADDRESS: 512 Carrollton Ave Balto Md

24a. REC'D BY REGISTRAR DATE: OCT 1 '58

24b. REGISTRAR'S SIGNATURE: Cathryn L Hood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09749

9776 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel County MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park Md.
c. LENGTH OF STAY IN 1b 68 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY A A Co.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First Vona Middle Last Bradford

4. DATE OF DEATH Month Sept. Day 27 Year 1958

5 SEX Female
6. COLOR OR RACE C.
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar 30th 1895
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Caleb Briggs
14. MOTHER'S MAIDEN NAME Eleanor Briggs Anne Arundel Co Md

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO No
17. INFORMANT Address Elizabeth Deale.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH 2 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary artery disease

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8/25/58 19____ to 9/27/58 19____ that I last saw the deceased alive on 9/20/58 19____, and that death occurred at 12:45 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE John F. Fitzpatrick M.D. ADDRESS (Street, city or town, state) Glen Burnie Md. DATE SIGNED 9/29/58

PHYSICIAN'S NAME (Type) JOHN G. ALEXANDER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 10/1/1958
22c. NAME OF CEMETERY OR CREMATORY St. Rest Cem.
22d LOCATION (City, town, or county) Brooklyn (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE Mrs Kate R. Williams ADDRESS 322 N. Schroeder St.
24a. REC'D BY REGISTRAR DATE OCT 1 '58
24b. REGISTRAR'S SIGNATURE Carlton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relocated by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09750

9777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1½ yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 220 6th Ave NE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 220 6th Ave NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: R. — Last: Bromley

4. DATE OF DEATH: Month: Sept. — Day: 18 — Year: 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Lowe

14. MOTHER'S MAIDEN NAME: ? ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO: ----

17. INFORMANT: Mrs R. P. Ward, same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

1 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertension — 3 years.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1952, to 9/17/58, 19, that I last saw the deceased alive on 9/17/58, 19, and that death occurred at 11 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustus P Faubert M.D. — ADDRESS (Street, city or town, state): 5 First Ave SE, Glen Burnie, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): G. H. Faubert, M.D., 5 First Ave SE, Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/20/58

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James H. Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 22 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Ward

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09751

9778 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY ANNE ARUNDEL MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE
c. LENGTH OF STAY IN 1b three days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a STATE Maryland b COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco 16X-2
d STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First DAVID Middle — Last BROOKS

4. DATE OF DEATH Month 9 Day 12 Year 1958

5. SEX M

6. COLOR OR RACE C

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH OCT 5 1891

9 AGE (In years last birthday) 66 yrs

IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY —

11 BIRTHPLACE (State or foreign country) USA

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jerry Brooks

14. MOTHER'S MAIDEN NAME Mary Brooks (married name)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)

16 SOCIAL SECURITY NO —

17. INFORMANT Address HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure (Acute)

DUE TO (b) Cardiovascular Disease

DUE TO (c) —

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —

20c. TIME OF INJURY Hour a. m. p. m. Month — Day — Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from 9/9 19 58 to 9/12 19 58 that I last saw the deceased alive on 9/12 19 58, and that death occurred at 10:15 A M, from the causes and on the date stated above

ACTUAL SIGNATURE L Benedict M.D. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED

PHYSICIAN'S NAME (Type) L. BENEDICT M.D. Crownsville, Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 9/14/58

22c. NAME OF CEMETERY OR CREMATORY St. Phillips

22d LOCATION (City, town, or county) (State) Aquasco Md.

23. FUNERAL DIRECTOR'S SIGNATURE Thos. E. Nelson ADDRESS Aquasco Md.

24a. RECD BY REGISTRAR DATE SEP 15 58

24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9747 — Reg. Dist. No. 09752

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville, RFD
d. STREET ADDRESS: Crain Highway
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOSEPH Middle WILLIAM Last BROSH
4. DATE OF DEATH: Month September Day 15, Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 25, 190[illegible]
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James J. Brosh, Sr.
14. MOTHER'S MAIDEN NAME: Mary Skoda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): ////////
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Amelia M. Brosh — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia - terminal Carcinoma
DUE TO (b): Carcinoma of pancreas with Metastases.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/14, 1958 to 9/15, 1958, that I last saw the deceased alive on 9/14, 1958, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Fred Hawkins, Jr. M.D.
ADDRESS (Street, city or town, state): 201 Balto-Annapolis Blvd, Glen Burnie, Md.
DATE SIGNED: 9/15/58
PHYSICIAN'S NAME (Type): J. Fred HAWKINS, Jr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 19/58
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 18 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69753

9748 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN Tb:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1943 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle B. — Last BROWN
4. DATE OF DEATH: Month September — Day 25 — Year 1958

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-13-58
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days 11
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanley B. Brown
14. MOTHER'S MAIDEN NAME: Ann Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: —
17. INFORMANT: Ann Palmer — Address: 1943 West St. Anna. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonitis. — INTERVAL BETWEEN ONSET AND DEATH:
763.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D
EXAMINER'S NAME (Type): Paul F. Guerin, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 9/25/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-1-58
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill Cem.
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: William Leese II
ADDRESS: Anna. Md.
24a. REC'D BY REGISTRAR DATE: OCT 2 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (19754

9779 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Herald Harbor Crownsville Md.
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Annearundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Herald Harbor Crownsville, Md.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ettie Middle L. Last Burdette

4. DATE OF DEATH: Month Sept Day 21 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1858

9. AGE (If years last birthday): 100 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Mary Land

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALMANZA LAYTON

14. MOTHER'S MAIDEN NAME: JULIA W. LACEY

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: John L. Walsh, Herald Harbor Crownsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio-sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1946 to Sept 21, 1958, that I last saw the deceased alive on Sept 20, 1958, and that death occurred at 2 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: Edward Merritt M.D. — ADDRESS (Street, city or town, state): Gambrills Md — DATE SIGNED: 9-22-58

PHYSICIAN'S NAME (Type): Edward Merritt — Gambrill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/25/58

22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery

22d. LOCATION (City, town, or county) (State): Boyd Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: SEP 26 '58

24b. REGISTRAR'S SIGNATURE: Cathryn S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09755

Reg. Dist. No. 9780

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #1 Gill st.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: #1 Gill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: E.; Last: Burton
4. DATE OF DEATH: September 9, 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 9, 1956
9. AGE (In years last birthday): 2 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: ////////////
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Calvin A. Burton
14. MOTHER'S MAIDEN NAME: Mildred E. Goolsby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ////////
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Calvin A. Burton, Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxiation due to ////// regurgitation of
DUE TO (b): food as deceased had a congenital paralysis of
DUE TO (c): oesophagus.
INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 756.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): As above stated in #18
20c. TIME OF INJURY: Hour: 3.20 p.m. Month, Day, Year: 9/9/58 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Odenton (County): A.A. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/9/58
NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 12/58
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.
22d. LOCATION (City, town, or county): Glen Burnie, (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 '58
24b. REGISTRAR'S SIGNATURE: Chilton L. Hewitt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09756

9749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elliott Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Elliott Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF [redacted] (Type or print): First: Elise Middle: Mohler Last: Buser

4. DATE OF DEATH: Month: 9- Day: 22 Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 15-1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Switzerland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wilhelm Mohler

14. MOTHER'S MAIDEN NAME: Rosine Dreider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓ (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm Buser Address: Annapolis R 7B Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, primary ?
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to 9-22-58 19____, that I last saw the deceased alive on 9-26-, 1956, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. ADDRESS (Street, city or town, state): 12 Cathedral St DATE SIGNED: 9.27.58

PHYSICIAN'S NAME (Type): Frank M Shipley Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-29-58

22c. NAME OF CEMETERY OR CREMATORY: St James Cem

22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: SEP 29 '58

24b. REGISTRAR'S SIGNATURE: Evelyn L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9781 **CERTIFICATE OF DEATH** Reg. Dist. No. 09757

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1415 McCulloh St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: John Middle: — Last: Carter
4. DATE OF DEATH Month: 9 Day: 1st Year: 1958
5. SEX M
6. COLOR OR RACE C.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-10-1877
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) —
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Fairfax
14. MOTHER'S MAIDEN NAME Lizzie Kinsley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 220-09-9411
17. INFORMANT Charlie Stewart Address —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular
DUE TO (c) Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Urinary Infection - Chronic Cystitis Prostatis
19. WAS AUTOPSY PERFORMED? -YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/22, 1958 to 9/1, 1958, that I last saw the deceased alive on 9/1, 1958, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James Hunter M.D. ADDRESS (Street, city or town, state) 10 Pill St Catonsville DATE SIGNED

PHYSICIAN'S NAME (Type) James Hunter 9/4/58.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-20-58
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem & C. Co
22d. LOCATION (City, town, or county) (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rayner Sanders 317 E Preston St
24a. REC'D BY REGISTRAR DATE SEP 29 '58
24b. REGISTRAR'S SIGNATURE Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M ///SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9782

Reg. Dist. No. 09758

1. PLACE OF DEATH
a COUNTY: Anne Arundel — STATE: MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
STATE: Maryland — b COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1007 Providence St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Anty — Last: Cornish

4. DATE OF DEATH: Month: September — Day: 3 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, ~~1958~~ 1888

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caterer

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: William H. Cornish

14. MOTHER'S MAIDEN NAME: Elisabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pyelonephritis
DUE TO
(c): Prostate Hypertrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ---- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 15, 1958, to ~~Aug~~ Sept. 3 1958 that I last saw the deceased alive on September 2, 1958, and that death occurred at 12:04 am, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel Mc Kenry Mapp, M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital
DATE SIGNED:

PHYSICIAN'S NAME (Type): Lionel Mc Kenry Mapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 8-58
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem Cem
22d. LOCATION (City, town, or county): Baltimore (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Eugene A. Hemmy
ADDRESS: 57 W. Biddle St.
24a. REC'D BY REGISTRAR DATE: SEP 5 '58
24b REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9783

CERTIFICATE OF DEATH

Reg. Dist. No. 09759

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION 2 Clifton Ave

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md.
b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold MD.
d. STREET ADDRESS 2 Clifton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Meta Middle: Geyer Last: Cowenhoven

4. DATE OF DEATH Month: 9 Day: 24 Year: 58 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 30, 1877.

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Martinsburg W. Va. U.S.

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME: James F Geyer.

14. MOTHER'S MAIDEN NAME: Hannah V. Stauffer. (Stoliper)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Daughter Mrs Va Tenant (Evans) Address

I

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage.
DUE TO (b): arteriosclerotic C. V. Disease
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1958, 19____, to 1958, 19____, that I last saw the deceased alive on 9-24-58, 19____, and that death occurred at 5:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Robert R Hahn M.D. ADDRESS (Street, city or town, state): Severna Park Md DATE SIGNED: 9-24-58

PHYSICIAN'S NAME (Type): Robert R. HAHN Severna Park MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-26-1958

22c. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery

22d LOCATION (City, town, or county) (State): Martinsburg, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. K. Brown ADDRESS: Martinsburg, W. Va.

24a REC'D BY REGISTRAR DATE: SEP 26 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9750 **CERTIFICATE OF DEATH** 09760

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
c. LENGTH OF STAY IN 1b: 61 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hospital, Anna. Md.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 110 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Ella — Last: CRANFORD

4. DATE OF DEATH: Month: SEP — Day: 13 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8 Feb 1897

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: WILLIAM EDWARD LAMB

14. MOTHER'S MAIDEN NAME: CARRIE REGINA BURK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.:

17. INFORMANT: U.S.Naval Hospital, Annapolis, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: More than 6

170X

DUE TO
(b): Carcinoma, rt. breast — 4 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Right pleural effusion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-29, 1958, to 9-12, 1958, that I last saw the deceased alive on 9-12, 1958, and that death occurred at 6:30A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert C. Lanning M.D. — ADDRESS (Street, city or town, state): U.S.Naval Hosp. Annapolis, Md. — DATE SIGNED: 9-13-58

PHYSICIAN'S NAME (Type): LCDR Robert C. LANNING MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 16, 58

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemeteery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 17 '58

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9784 # MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Fil. 234 10-16-58 et

Reg. Dist. No. 09761

1. PLACE OF DEATH
a. COUNTY A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY A.A.Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md
d. STREET ADDRESS Dale Road e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EARL Middle S. Last CROSHAW
4. DATE OF DEATH Month 9 Day 8 Year 1958
5. SEX M. 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 21, 1880
9. AGE (At years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O RR
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Croshaw Address Crownsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. Linhardt.
DATE SIGNED 9/8/58.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-8-58
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.
22d. LOCATION (City, town, or county) Brooklyn, (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home ADDRESS 120 E. Fort Ave
24a. REC'D BY REGISTRAR DATE SEP 9 58
24b. REGISTRAR'S SIGNATURE Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9785

CERTIFICATE OF DEATH

09762

Reg. Dist. No.

1. PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1y 4m 4d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland — b COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlotte Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First Mamie — Middle — Last Dade
4. DATE OF DEATH: Month 9 — Day 21 — Year 1958

5 SEX: Female
6. COLOR OR RACE: Negro
7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8 DATE OF BIRTH: [redacted] 1898
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): ACVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis
19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ---
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: ---
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 5/17, 1957, to 9/21, 1958, that I last saw the deceased alive on 9/21/58, 19, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 9/22/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
Crownsville State Hospital, Md. 9/22/58

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 9/25/58
22c NAME OF CEMETERY OR CREMATORY: Ebezener
22d LOCATION (City, town, or county) (State): New Market, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Clarke Mattingley — ADDRESS: Leonardtown, Md.
24a REC'D BY REGISTRAR DATE: SEP 29 '58
24b REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09763

9751 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
c. LENGTH OF STAY IN 1b: 12 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.N.H. Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Herald Harbor
d. STREET ADDRESS: Crownsville, P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ersal — Middle Dayton — Last DAVEY

4. DATE OF DEATH: Month Sep. — Day 8 — Year 19 58

5. SEX: M

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-30-93

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Marine Corps

10b. KIND OF BUSINESS OR INDUSTRY: U.S.M.C.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John DAVEY

14. MOTHER'S MAIDEN NAME: Bertha SCHAEFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI WWII

16. SOCIAL SECURITY NO.: 217-30-4886

17. INFORMANT Address: U.S.Naval Hospital, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANOXIA — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
DUE TO
241X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Status Asthmaticus — 5 Days
DUE TO
(c): Bronchial Asthma — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 Sep, 1958, to 8 Sep, 1958, that I last saw the deceased alive on 8 Sep, 1958, and that death occurred at 4:05A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. L. Gould M.D. ADDRESS (Street, city or town, state): U.S.N.Hosp. Annapolis, Md. DATE SIGNED: 9-8-58

PHYSICIAN'S NAME (Type): E. L. GOULD LT MC USNR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Sept. 11,1958
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 15 '58

24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Form 233 9/10/58 proj

9786

CERTIFICATE OF DEATH

Reg. Dist. No. 19764

1. PLACE OF DEATH a. COUNTY: Allegany Co Md — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marley Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: A.H.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marley Park X
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First George — Middle — Last Hersey
4. DATE OF DEATH: Month 9 — Day 9 — Year 19 58

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-18-1885
9. AGE (In years last birthday): 73 Yrs. 7 Mos.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Longshore
11. BIRTHPLACE (State or foreign country): a a Co Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Howard Hersey
14. MOTHER'S MAIDEN NAME: Louise Grimage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Address): Laura Hersey Marley Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the rectum — INTERVAL BETWEEN ONSET AND DEATH: 1 year
154 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 10 19 58 to Sept 9 19 58, that I last saw the deceased alive on Sept 2 19 58, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Pasadena Maryland — DATE SIGNED: Sept. 9 1958

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/13/58 — 22c. NAME OF CEMETERY OR CREMATORY: Marley Neck — 22d. LOCATION (City, town, or county) (State): A A Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Isaac L Brown — ADDRESS: Montgomery St

24a. REC'D BY REGISTRAR DATE SEP 11 '58 — 24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9752

CERTIFICATE OF DEATH

09765

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 18 HR.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GEN. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MAYO
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First ROLAND — Middle L. — Last DOWNS

4. DATE OF DEATH: Month SEPT — Day 8 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 13 AUGUST '58

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months — Days 25; IF UNDER 24 HRS Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND B.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM DOWNS

14. MOTHER'S MAIDEN NAME: BEATRICE THOMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DEHYDRATION — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DIARRHEA, NON-SPECIFIC — 3 DAYS
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MALNUTRITION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 7 SEPT, 19 58, to 8 SEPT, 19 58, that I last saw the deceased alive on 7 SEPT, 19 58, and that death occurred at 5:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James J. Hudson, Jr. M.D. — ADDRESS (Street, city or town, state): RIVER CLUB ESTATES EDGEWATER, MD. — DATE SIGNED: 9 SEPT 58

PHYSICIAN'S NAME (Type): JAMES J. HUDSON, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-10-58

22c. NAME OF CEMETERY OR CREMATORY: St. Marks

22d. LOCATION (City, town, or county) (State): Edgewater, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese II — ADDRESS: Annap, Md

24a. REC'D BY REGISTRAR DATE: SEP 17 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relocated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9787 CERTIFICATE OF DEATH

Reg. Dist. No. 09766

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - RIVIERA BEACH
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FORT SMALLWOOD ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - RIVIERA BEACH
d. STREET ADDRESS: 1 FORT SMALLWOOD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle — Last EDELMANN

4. DATE OF DEATH: Month SEPT. Day 27 Year 1958

5 SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
MALE	WHITE		FEB. 3, 1885	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
IRON MOULDER	IRON FOUNDRY	BALTIMORE, MARYLAND	U.S.A.

13. FATHER'S NAME: JOHN EDELMANN

14 MOTHER'S MAIDEN NAME: MARGIE MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
NO	218-01-6034	MRS. ANNIE THOMAS	FORT SMALLWOOD ROAD PASADENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from SEPT 19, 1958, to SEPT. 27, 1958, that I last saw the deceased alive on SEPT. 26, 1958, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): RIVIERA BEACH — DATE SIGNED: 9/27/58

PHYSICIAN'S NAME (Type): J. BRADY SMITH — PASADENA, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-30-58	~~McCully~~ Cedar Hill	Brooklyn - Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
McCully Funeral Homes	130 E. Fort Ave	OCT 1 '58	Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9753 — 19767

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Best Gate, Md.
d. STREET ADDRESS: 111 Maybelle Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: A. — Last: Edwards

4. DATE OF DEATH: Month: 9 — Day: 10 — Year: 19 58

5. SEX: Male — 6. COLOR OR RACE: Colored — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 1-5-1923 — 9. AGE (In years last birthday): 35 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Waterburg Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Edwards — 14. MOTHER'S MAIDEN NAME: Lillian Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mary Edwards — Address: 111 Maybelle Ave. Best Gate Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 835x — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Multiple Injuries.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Crash between Hopper & truck body

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 9.9.58 — 20d. INJURY OCCURRED: While at work ☒ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — 20f. (City or town) (County) (State): A.A.Co

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Luhardt — M D — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 9.10.58

EXAMINER'S NAME (Type): E. Luhardt.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-14-58 — 22c. NAME OF CEMETERY OR CREMATORY: Fowlers — 22d. LOCATION (City, town, or county) (State): Best Gate, Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Hyser Jr. — ADDRESS: Annapolis Md — 24a. REC'D BY REGISTRAR DATE: 9/17/58 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9754 — 09768 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Hebron Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ilchart
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: [redacted] Howard Exum
4. DATE OF DEATH Month 9 Day 11 Year 19[redacted]
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-27-1942
9. AGE (In years last birthday) 16 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Harvey W. Exum
14. MOTHER'S MAIDEN NAME Mildred Heard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address: Harvey W. Exum #[redacted]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) multiple injuries — INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
813 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Auto - E178
20c. TIME OF INJURY Month, Day, Year: Hour ~~a. m.~~ p. m. 9-11-1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) [redacted] (County) Howard (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9-11-58

EXAMINER'S NAME (Type) E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-14-58
22c. NAME OF CEMETERY OR CREMATORY Hillcrest
22d. LOCATION (City, town, or county) Ellicott City (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Ellicott City, Md.
24a. REC'D BY REGISTRAR DATE SEP 15 '58
24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Page 6 is for cremation.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09769

1 M 9788

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN PARK.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 208 W 12th Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKLYN PARK.
d. STREET ADDRESS: 208 W 12th AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LULA Middle GRACE Last FEUERSTEIN

4. DATE OF DEATH: Month SEPT. Day 7 Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEB 12, 1874
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL TAYLOR
14. MOTHER'S MAIDEN NAME: SARAH E. LABARRE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MRS. EMMA FORSYTHE Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Dehydration - Acidosis - Cachexia - Shock — INTERVAL BETWEEN ONSET AND DEATH:
586X
DUE TO (b): Hemorrhage — 6-Sept 58
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Perforation - Gall Bladder + Generalized A.S.C.V.H.D. — 7-Sept 58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m / p. m 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 Aug, 1958 to 6 Sept, 1958, that I last saw the deceased alive on 6 Sept 58, 19____, and that death occurred at 9 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew Sosnowski M.D.
ADDRESS (Street, city or town, state): 4016 Ritchie Hiway
DATE SIGNED: 9 Sept 58
PHYSICIAN'S NAME (Type): Andrew R. Sosnowski

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Sept 19 1958
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM
22d LOCATION (City, town, or county) (State): RITCHIE Hgwy AA Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George J. Jones ADDRESS: 4001 Ritchie Hgwy
24a. REC'D BY REGISTRAR DATE: SEP 11 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9789

Reg. Dist. No. 09770

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Best Gate
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Best Gate
d. STREET ADDRESS: Box 410
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aline — Middle: — Last: Galloway

4. DATE OF DEATH: Month: 9 — Day: 17 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-4-1912

9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Edgewater, Md.

12. CITIZEN OF (WHAT COUNTRY?): U.S.A.

13. FATHER'S NAME: Benny Brown

14. MOTHER'S MAIDEN NAME: Mary L. Vaulx

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elijah Galloway — Address: Best Gate, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca of Liver — INTERVAL BETWEEN ONSET AND DEATH: 6 mon
DUE TO
156.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year: Hour: a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 9/12, 1958, to 9/0, 1958, that I last saw the deceased alive on 9/11, 1958, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson M.D. — ADDRESS (Street, city or town, state): 37 Cathedral St — DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. THEODORE H. JOHNSON — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-21-58 — 22c. NAME OF CEMETERY OR CREMATORY: Hope Chapel — 22d. LOCATION (City, town, or county) (State): Edgewater, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR: SEP 23 58 — 24b. REGISTRAR'S SIGNATURE: Elijah S. Kraus — DATE: [redacted]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9790 **CERTIFICATE OF DEATH** Reg. Dist. No. 9771

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Children's Center

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1636 No 4th St, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James Middle Peter Last Gayles

4. DATE OF DEATH: Month Sept. Day 22 Year 1958

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 26 1957
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Jupiter Gayles
14. MOTHER'S MAIDEN NAME: Lillian Lorraine Gayles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: mother Lillian Lorraine Gayles Address: 1636 4th St, N.W., Wash DC.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
752x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Pyelitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐, OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/23 19 58 to 9/22 19 58 that I last saw the deceased alive on 9/22 19 58, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. ADDRESS (Street, city or town, state): Children's Center, Laurel, Md. DATE SIGNED: 9/23/58

PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 24, 1958
22c. NAME OF CEMETERY OR CREMATORY: District Training School
22d. LOCATION (City, town, or county) (State): Laurel, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Doney Jr.
ADDRESS: District Training School Laurel, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 26 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9791 CERTIFICATE OF DEATH

Reg. Dist. No. 9772

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9y 2m 25d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last Giles

4. DATE OF DEATH: Month 9 — Day 26 — Year 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1904

9. AGE (In years last birthday): 54 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ---

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Acute Cardiac Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Chronic Brain Syndrome with CNS Lues

DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of left hip

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---

20c. TIME OF INJURY Month, Day, Year, Hour ---, p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State) ---

21. I certify that I attended the deceased from 7/1, 1949, to 9/26, 1958, that I last saw the deceased alive on 9/26/, 1958, and that death occurred at 12:30P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D

ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.

DATE SIGNED: 9/26/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

Crownsville State Hospital, Md. 9/26/58

22a BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 9-29-58

22c. NAME OF CEMETERY OR CREMATORY: U of Md

22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Anna. Md.

24a. REC'D BY REGISTRAR DATE SEP 30 '58

24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9792 CERTIFICATE OF DEATH

Reg. Dist. No. 9773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BAR HARBOR
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: 3 Vol-11
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 127 E. CLEMENT ST
d. STREET ADDRESS: Baltimore, MD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Hubert Last: Crawling
4. DATE OF DEATH: Month: 9 Day: 15 Year: 1958
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 13, 1894
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Mech. Eng.
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John N. Crawling
14. MOTHER'S MAIDEN NAME: Augusta Fischer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 212-07-9876
17. INFORMANT: Family Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: about 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardio Vascular disease (2)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/29, 1948, to 9/15, 1958, that I last saw the deceased alive on 9/14, 1958, and that death occurred at 10 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Deibel M.D. ADDRESS (Street, city or town, state): 122 E Hanover St DATE SIGNED:
PHYSICIAN'S NAME (Type): DR. HARRY DEIBEL Baltimore 30 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-17-58
22c. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully Funeral Homes ADDRESS: 130 E. Fort Ave
24a. REC'D BY REGISTRAR DATE: SEP 18 '58
24b. REGISTRAR'S SIGNATURE: Esther L. Kemp

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9793 CERTIFICATE OF DEATH

Reg. Dist. No. 19774

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover, Md
c. LENGTH OF STAY IN 1b 37 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridge Rd. Box 120 D

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover Md
d. STREET ADDRESS Ridge Road Box 120 D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First John Middle Gratzinger Last
4. DATE OF DEATH Month Sept Day 24 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 11, 1898
9. AGE (If years last birthday) 60 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Gottlieb Gratzinger
14. MOTHER'S MAIDEN NAME Anna Otto

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ✓
16. SOCIAL SECURITY NO
17. INFORMANT Mrs Mary E. Gratzinger Address Ridge Rd Hanover Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) Recurrent
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Chronic Myocardial Insufficiency — 1½ Yrs
DUE TO (d) Essential Arteriosclerosis — 4 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 1925 to Sept 24, 1958; that I last saw the deceased alive on Sept 22, 1958, and that death occurred at 12:22 M, from the causes and on the date stated above.

ACTUAL SIGNATURE B B Brumbaugh M.D. ADDRESS (Street, city or town, state) 609 Main St DATE SIGNED 9/24/58
PHYSICIAN'S NAME (Type) B B Brumbaugh Glen Burnie 27 Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/27/58
22c. NAME OF CEMETERY OR CREMATORY Loudon Park
22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balto 27 Md

23. FUNERAL DIRECTOR'S SIGNATURE H. Conwell Hall ADDRESS 90 Hollins St
24a. REC'D BY REGISTRAR DATE SEP 25 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7,12 Filed 10-14-58 bt

9794

CERTIFICATE OF DEATH

09775

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River md
c. LENGTH OF STAY IN 1b: 1 yr 8 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clarence Middle: H. Last: Gray

4. DATE OF DEATH: Month: Sept. Day: 12 Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 26

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Educator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Calcutta India

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francisco Gray

14. MOTHER'S MAIDEN NAME: Sharma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Barrington Guy Sharma
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Coronary arteriosclerosis

DUE TO (c): Chronic nephritis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. S.T.D.X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. / p. m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1958, to Sept 12, 1958, that I last saw the deceased alive on Sept 9, 1958, and that death occurred at 11:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Calvin M.D. ADDRESS (Street, city or town, state): Lothian, md DATE SIGNED: 9-15-58

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

22b. DATE THEREOF: Sept 15/58

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or county) (State): Bladensburg md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty ADDRESS: Glenndale md

24a. REC'D BY REGISTRAR DATE: SEP 16 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. (Cremation may be retained by the Board of Health) TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09776
Reg. Dist. No.

Item 1 Film G23h 12/1/58 ggi

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
9795
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 175

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Fifth st., Box 161 X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERVY Middle LEE Last HAWKS

4. DATE OF DEATH: Month Sept. Day 19 Year 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 7, 1899
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Nat'l. Plastic
11. BIRTHPLACE (State or foreign country): Pettit Co., Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Hawks
14. MOTHER'S MAIDEN NAME: Rhody Pucket

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ///////
16. SOCIAL SECURITY NO.: 230 05 8225
17. INFORMANT: (daughter) Address: Miss Christine Hawks Same As #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Internal abdominal injuries, Comm. compound fracture — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): ofright leg(below knee)fracture of left femur and left humerus. Multiple lacerations. — Sud'en
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Was hit by a car while crossing route 175, Odenton, Md.
20c. TIME OF INJURY: Hour a.m. p.m. 6.10 A.M. Month, Day, Year 9/19/58 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): route 175
20f. (City or town) Odenton (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Paubert M.D.
EXAMINER'S NAME (Type): Gustave H. Paubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/19/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 21/58
22c. NAME OF CEMETERY OR CREMATORY: Done Run Cemetery
22d. LOCATION (City, town, or county) (State): Mount Airy N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. E. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 22 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Hurd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

9796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1m 22d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1813 Bentalou Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Washington — Last: Holmes

4. DATE OF DEATH: Month: 9 — Day: 30 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/22/74

9. AGE (In years last birthday): 84 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Holmes

14. MOTHER'S MAIDEN NAME: Rachel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ———

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): 422.1 ACVD
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour: ——— a. m. / p. m. — Month, Day, Year 19 ———

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from 8/8 1958, to 9/30 1958, that I last saw the deceased alive on 9/30 1958, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/30/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. 9/30/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/4/1958

22c. NAME OF CEMETERY OR CREMATORY: [illegible] Memorial Cem.

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: OCT 3 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 [illegible]

9797

CERTIFICATE OF DEATH

Reg. Dist. No. 09738

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 1956 W. Mulberry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Vernon — Middle — Last Jackson
4. DATE OF DEATH: Month 9 — Day 19 — Year 1958

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Jacob Jackson
14. MOTHER'S MAIDEN NAME: Hattie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ---
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart failure
443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive cardiovascular disease
DUE TO (c): Chronic Brain Syndrome Associated with generalized Arteriosclerosis.
INTERVAL BETWEEN ONSET AND DEATH: Known to ~~us since~~ admission

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 026 X CNS Syphilis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---
20c. TIME OF INJURY Month, Day, Year Hour a. m --- p. m 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) ---

21. I certify that I attended the deceased from 9/5/ 1958, to 9/19/ 1958, that I last saw the deceased alive on 9/19/ 1958, and that death occurred at 8:33 A.M., from the causes and on the date stated above

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
M.D
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 9-19-58

Crownsville State Hospital, Md. 9-19-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 23/58
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
22d LOCATION (City, town, or county) (State): West Pat. Balto. Md

23 FUNERAL DIRECTOR'S SIGNATURE: Milspaugh Funeral Home Inc.
ADDRESS: 1424 Laurens St
24a. REC'D BY REGISTRAR DATE: Sept. 19/58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna
SEP 22 '58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9755 **CERTIFICATE OF DEATH** 09779

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundle — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: RFD 3, Box 360
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Carl — Middle Henry — Last JONES

4. DATE OF DEATH: Month SEPTEMBER — Day 1 — Year 19 58

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 June 1893

9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired USN

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sydney M. JONES

14. MOTHER'S MAIDEN NAME: Mary Jane WHITTLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1, WW 11

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PANCREATITIS, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 2½ months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Penetrating Peptic Ulcer

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 22 June, 19 58 to 1 September, 19 58 that I last saw the deceased alive on 1 Septembrr, 19 58, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T Connelly M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): T. P. CONNELLY CAPTAIN MC USN USNH, ANNAPOLIS, MD. 9-1-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/4/58
22c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Academy
22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible] Md.

24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9798 CERTIFICATE OF DEATH

09780

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 205 Ruethe Road

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d. STREET ADDRESS: 205 Ruethe Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Marie Middle Bernadette Last Jones

4. DATE OF DEATH: Month 9 Day 25 Year 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 3, 1881
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Owen F. Murray
14. MOTHER'S MAIDEN NAME: Mary Jane Cady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Mildred M. Jones — Address: Same As Ab

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardio-vascular Dis.
DUE TO: Hrt
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 57, to Sept, 19 58, that I last saw the deceased alive on Sept 23, 19 58, and that death occurred at 4:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Christopher Mink M.D.
ADDRESS (Street, city or town, state): BCH Clinic Hwy
DATE SIGNED: 9-25-58

PHYSICIAN'S NAME (Type): C. B. MacDonald, ME
Glen Burnie Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept-27, 1958
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. V. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 29 58
24b. REGISTRAR'S SIGNATURE: Wilbur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9799 **CERTIFICATE OF DEATH** Reg. Dist. No. 09781

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Telegraph Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XSevern
d. STREET ADDRESS: Telegraph Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NANNIE Middle MAE Last KNIGHT

4. DATE OF DEATH: Month September Day 13 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 7, 1885
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR Months / Days / IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Hammond
14. MOTHER'S MAIDEN NAME: Marjnary (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ////////
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mr. Alfonso J. Knight — Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diabetic Gangrene — INTERVAL BETWEEN ONSET AND DEATH: 4 years
260X
DUE TO (b): Diabetes Mellitus — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1946 to Sept 13, 1958 that I last saw the deceased alive on Sept 12, 1958, and that death occurred at 2:56 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward G Merritt M.D. — ADDRESS (Street, city or town, state): Edmonds Md — DATE SIGNED: 9-15-58

PHYSICIAN'S NAME (Type): Edward G. Merritt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 16/58
22c. NAME OF CEMETERY OR CREMATORY: Nickols-Bethel Ch. Cem.
22d. LOCATION (City, town, or county) (State): Odenton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard P. Leggett — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 18 '58
24b. REGISTRAR'S SIGNATURE: Cinlus L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 19782

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. A. Army Hospital

9800

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hanover
d. STREET ADDRESS: Box 235 Maple Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LESLIE Middle BRUCE Last KNOTT

4. DATE OF DEATH: Month September Day 19 Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 23 1939

9. AGE (In years last birthday): 18 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Army Gar.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman Olen Knott

14. MOTHER'S MAIDEN NAME: Avis Francis Foley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT Address: Mr. Herman Olen Knott (father)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of skull and multiple lacerations of

835X

DUE TO (b): body.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell offa farm type tractor to a gravel road.

20c. TIME OF INJURY: Hour 0715 o. m. p. m. Month 9 Day 19 Year 1958

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Golf Course

20f. (City or town) (County) (State): Fort Meade Anne Arundel Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D.

EXAMINER'S NAME (Type): Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9/22/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-23-1958

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Ritchie Hghy. Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas J. Kenny, Inc.

ADDRESS: 1600 hollins street

24a. REC'D BY REGISTRAR DATE: 9/22/58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09783

9801 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 405 Wayside Alley
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph; Middle: ; Last: Knox

4. DATE OF DEATH: Month: 9; Day: 5; Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1871

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH:

023X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Aortic Regurgitation - probably luetic

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Decubitus Ulcers - Lower gastrointestinal hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.):

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/29, 1958, to 9/5, 1958, that I last saw the deceased alive on 9/5/58, 1958 and that death occurred at 4:35 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: L Benedict M.D

ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.

DATE SIGNED: 9-8-58

PHYSICIAN'S NAME (Type): L. Benedict, M. D.

Crownsville State Hospital, Md. 9-8-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 9, 1958

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Troy O Wilson

ADDRESS: 1000 Brantley Ave.

24a. REC'D BY REGISTRAR DATE: 9 58

24b. REGISTRAR'S SIGNATURE: Arthur L. Pierce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9802 CERTIFICATE OF DEATH

Reg. Dist. No. 09784

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEVERNA PARK
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIE — Middle JOCHEN — Last KROGER
4. DATE OF DEATH: Month September — Day 9 — Year 1958
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT 21, 1894
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MICHIGAN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ALBERT JOCHEN
14. MOTHER'S MAIDEN NAME: MARY WALTERS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: WILLIAM F. KROGER — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic carcinoma of the Liver — INTERVAL BETWEEN ONSET AND DEATH:
156.2
DUE TO (b): Primary site undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 4, 1958, to Sept. 9, 1958 that I last saw the deceased alive on Sept. 9, 1958 and that death occurred at 3:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Francis I. Codd M.D. — ADDRESS (Street, city or town, state): Severna Park, Maryland — DATE SIGNED: 9-9-58

PHYSICIAN'S NAME (Type): Francis I. Codd M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: SEPT 11, 1958
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN
22d. LOCATION (City, town, or county) (State): PRINCE GEO. CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor — ADDRESS: Sev. Annapolis Md
24a. REC'D BY REGISTRAR DATE: SEP 15 58
24b. REGISTRAR'S SIGNATURE: Chas S Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9803 — 69785 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland. — b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena — c. LENGTH OF STAY IN 1b: 3 months — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Beauty Leach — d. STREET ADDRESS: 419 S.Ellwood Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Tuc (Kutz) — Last:
4. DATE OF DEATH: Month: September — Day: 14th. — Year: 1958
5. SEX: M. — 6. COLOR OR RACE: W. — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 3/19/89 — 9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired tavern keeper. — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Poland,Europe. — 12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: ? — 14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO — 17. INFORMANT: eo Tuscemison in law) — Address: Balti or . 15 E.36th .St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave K Faubert MD M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): Gustave . Faubert,..D. — 9/14/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept.17/58 — 22c. NAME OF CEMETERY OR CREMATORY: Holy Rosary — 22d. LOCATION (City, town, or county) (State): Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Ozazewski — ADDRESS: 1930 Eastern Ave
24a. REC'D BY REGISTRAR — DATE: SEP 16 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 filed 10-14-58 e.

9756

CERTIFICATE OF DEATH

09786

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood
d. STREET ADDRESS: 1 Weston Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Estep — Last: Lankford

4. DATE OF DEATH: Month: Sept — Day: 30 — Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 11-30-1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): A A Co Md
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Richard Tillard Estep
14. MOTHER'S MAIDEN NAME: Harriett Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Richard E Lankford. Address: Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary artery disease
DUE TO
(c): Pulmonary thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 26, 19 58 to Sept 30, 19 58, that I last saw the deceased alive on Sept 30, 19 58, and that death occurred at 10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. ADDRESS (Street, city or town, state): Lothian, Md. DATE SIGNED: 9-30 58

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 2-1958
22c. NAME OF CEMETERY OR CREMATORY: St James Cemt
22d. LOCATION (City, town, or county) (State): Traceys Landing A A Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md

24a. RECD BY REGISTRAR DATE: OCT 6 '58
24b. REGISTRAR'S SIGNATURE: Linton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9804

Reg. Dist. No. 09787

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 2yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Irene Ave

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE MD b. COUNTY A.A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
d. STREET ADDRESS 410 Irene Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ALBert Middle Andrew Lost Leggett
4. DATE OF DEATH Month 9 Day 22 Year 1958

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 17, 1893
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Produce
11. BIRTHPLACE (State or foreign country) Balto md
12. CITIZEN OF WHAT COUNTRY U. S.

13. FATHER'S NAME Albert S Leggett
14. MOTHER'S MAIDEN NAME Trogaser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Ye (If yes, give war or dates of service) Navy
16. SOCIAL SECURITY NO.
17. INFORMANT wife Mrs Leggett Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

443X

DUE TO (b) Hypertensive C. V. Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19____, to 1958, 19____, that I last saw the deceased alive on Sept 12, 19____, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park md DATE SIGNED 9-22-58

PHYSICIAN'S NAME (Type) Robert R. HAHN. Severna Park md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 25, 1958
22c. NAME OF CEMETERY OR CREMATORY New Cathedral
22d. LOCATION (City, town, or county) Baltimore (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE P. J. Singleton ADDRESS Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE SEP 25 '58
24b. REGISTRAR'S SIGNATURE Cathryn S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69788

9757 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A A General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Herold Harbor
d. STREET ADDRESS: Crownsville P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle P. Last Malloy
4. DATE OF DEATH: Month 9 Day 5 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-6-1912
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Sgt U.S. ARMY
10b. KIND OF BUSINESS OR INDUSTRY: Ret Sgt U.S.A
11. BIRTHPLACE (State or foreign country): New York City
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Peter Malloy
14. MOTHER'S MAIDEN NAME: Mary E. Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Viola K. Malloy — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/8/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 10-58
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: SEP 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Fraas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9805 — 09789 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Shadyside~~ AVALON SHORES
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Lerch & Oak Streets

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~~Shadyside~~ AVALON SHORES
f. STREET ADDRESS: Lerch & Oak Streets
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DONALD — Middle HOWARD — Last MANNING, JR.
4. DATE OF DEATH: Month Sept. — Day 18 — Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/19/58
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months 3 — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald Howard Manning, Sr.
14. MOTHER'S MAIDEN NAME: Martha Jean Claxton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mr. Donald H. Manning, Sr., Lerch & Oak Sts. Avalon Shores, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral pneumonitis
492X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M D
EXAMINER'S NAME (Type): Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 9/19/58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/20/58
22c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiska
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: SEP 22 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VE. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09790

9806 **CERTIFICATE OF DEATH**

Reg. Dist. No. Balto Co

1. PLACE OF DEATH
a. COUNTY Anne-Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
c. LENGTH OF STAY IN 1b 26 days
d. NAME OF HOSPITAL (If not in hospitol, give street address), OR INSTITUTION SANN'S - Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE Maryland- b. COUNTY ~~Anne-Arundel~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riesterstown-
d STREET ADDRESS Hanover-Pike-
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Martin
4. DATE OF DEATH Month 9 Day 19 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 9-26-1883
9. AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATE-Road
10b. KIND OF BUSINESS OR INDUSTRY Labor
11. BIRTHPLACE (State or foreign country) Pikesville-Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Martin
14. MOTHER'S MAIDEN NAME Maggie Logue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16 SOCIAL SECURITY NO. 218-10-0905
17. INFORMANT Mary-V-Sann- Address Millersville Cecil-Rd. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) Coma-Diabetic — 2 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension Cerebro Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 2-58 19 to Sept 11-58 19, that I last saw the deceased alive on Sept 11-58 19, and that death occurred at 2:15 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Joseph Lipskey M.D. ADDRESS (Street, city or town, state) Denton Md DATE SIGNED 9-20-58
PHYSICIAN'S NAME (Type) DR. JOSEPH LIPSKEY

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. PLACE OF ~~DENTON~~ MAR 23 1959
22c. NAME OF CEMETERY OR CREMATORY Sept. 22/58 Finksburg
22d. LOCATION (City, town, or county) (State) Finksburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.F.Eline & Sons, Reisterstown, Md.
24a. REC'D BY REGISTRAR DATE SEP 23 '58
24b REGISTRAR'S SIGNATURE Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 F... 3234 10-1-58 es

9758 **CERTIFICATE OF DEATH** Reg. Dist. No. 09791

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 110 Clay St. (Doctor's office)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) — a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 15 C. Ck. Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sharon Middle Elaine Last McGowans
4. DATE OF DEATH: Month 9 Day 18 Year 1958

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-11-1957
9. AGE (In years last birthday): 1 yrs — IF UNDER 1 YEAR: Months 2 Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis McGowans
14. MOTHER'S MAIDEN NAME: Naomi Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis McGowans Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebro-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/15 10:00 P.M., 1958, to 9/18 11:00 A.M., 19, that I last saw the deceased alive on 9/15, 1958, and that death occurred at 11:00 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: R. K. Richardson M.D. ADDRESS (Street, city or town, state): 110 Clay St. Annapolis DATE SIGNED: 9/17/58
PHYSICIAN'S NAME (Type): R. K. RICHARDSON M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF:
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II ADDRESS: Annap. Md.
24a. REC'D BY REGISTRAR DATE: SEP 23 '58
24b. REGISTRAR'S SIGNATURE: Helen S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9807

CERTIFICATE OF DEATH

09792
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Glen Burnie
c. LENGTH OF STAY IN 1b: 12 y.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 25 Brownside Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Glen Burnie
d. STREET ADDRESS: 25 Brownside Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: [illegible] Middle: [illegible] Last: [illegible]
4. DATE OF DEATH: Month: 9 Day: 20 Year: 1958
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10.22.1884
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: OwneHome
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Ignatius Christopher
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ////
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son: [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac insufficiency — INTERVAL BETWEEN ONSET AND DEATH:
422.2
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Coronary disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 19____, to ____ 19____, that I last saw the deceased alive on ____ 19____, and that death occurred at 6.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew D. Szabo M.D.
ADDRESS (Street, city or town, state): 3 Crain Highway, Glen Burnie Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Andrew D. Szabo

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 23/58
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Brooklyn, R.F.D., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. V. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: SEP 25 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9808 — 09793 — Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: A. Arundel — Glenburnie — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 18 Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Md — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn Md. R.F.D.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SANN'S-Nursing-Home-Millersville md. Cecil-Rd.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Elizabeth — Last: Mitchell
4. DATE OF DEATH: Month: 9 — Day: 30 — Year: 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-31-1879
9. AGE (In years last birthday): 78 yrs. 10
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herman-Mietzsch
14. MOTHER'S MAIDEN NAME: Bertha-SNITSPAHN.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mary-V-SANN — Address: Cecil-Rd. Millersville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Cardiac Fatty Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-11-58 19 to 9-30-58 that I last saw the deceased alive on 9-30-58 19, and that death occurred at 8 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Joseph Lipsky M.D. — ADDRESS (Street, city or town, state): Odenton Md 9-30-58
PHYSICIAN'S NAME (Type): JOSEPH LIPSKEY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 1 1958
22c. NAME OF CEMETERY OR CREMATORY: Woodfield
22d. LOCATION (City, town, or county) (State): Gaithersville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard O Hardesty — ADDRESS: Gaithersville Md
24a. REC'D BY REGISTRAR — DATE: OCT 6 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09794

9759 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Gen'l. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arunde
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Rt-1 - Box 387-
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma — Middle — Last Moore

4. DATE OF DEATH: Month September — Day 21, — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 4, 1905

9. AGE (If years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rosehill, Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lafette Hounshell

14. MOTHER'S MAIDEN NAME: Mary Hounshell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ////////

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. William E. Moore — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): hypertensive cardiovascular disease — 24 hrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): X diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 55 to Sept, 19 58, that I last saw the deceased alive on Sept 24, 19 58, and that death occurred at 9:09 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Bossuck M.D. — ADDRESS (Street, city or town, state): Annapolis, Md. — DATE SIGNED: 9/24/58

PHYSICIAN'S NAME (Type): S. Bossuck M.D. — Annapolis, Md.

22a. BURIAL CREMATION REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 24, 1958

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. V. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE SEP 25 '58

24b. REGISTRAR'S SIGNATURE: Curtis L. Evans

VS A1S (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09795

9809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville

c. LENGTH OF STAY IN 1b: 3 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

d. STREET ADDRESS: 630 Saratoga West.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: L. — Last: Nelson

4. DATE OF DEATH: Month: September — Day: 13 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 4, 1895

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10b. KIND OF BUSINESS OR INDUSTRY: Entertainment

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: United States

13. FATHER'S NAME: Unkn

14. MOTHER'S MAIDEN NAME: Unkn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WW I

16. SOCIAL SECURITY NO.: Unkn

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:
522X
DUE TO (b): Respiratory failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypostatic pheumonia — 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/12, 19 58, to 9/13, 19 58 that I last saw the deceased alive on 9/12/58, 19____, and that death occurred at 10:25 P. M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville, State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): L B — Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial Sept 25/58 — 22b. DATE THEREOF 9/18/58 — 22c. NAME OF CEMETERY OR CREMATORY: Balto Nat. Cemetery — 22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Mrs E. J. Ward Rinehold 1463 N. Carey St

24a. RECD BY REGISTRAR DATE: SEP 15 '58

24b. REGISTRAR'S SIGNATURE: Carlton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 shall be detached for use as the burial transit permit. Then please mave carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9760 **CERTIFICATE OF DEATH** 09796

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Anne Arundel County Gen'l Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Vol 1
d. STREET ADDRESS: 29 S. Bernice Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Catherine Middle Cecelia Last Nethken

4. DATE OF DEATH: Month Sept. Day 26, Year 1958

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 7, 1907
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick McTague
14. MOTHER'S MAIDEN NAME: Ellen Slattery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Charles Nethken — Address: 29 S. Bernice Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): obstructive jaundice ? ac. hepatitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) DUE TO: alcoholism. upon Laennec cirrhosis ?
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9-26-, 1958, to 9-26-, 1958, that I last saw the deceased alive on 9-26-58, 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St — DATE SIGNED: 9-26-58
PHYSICIAN'S NAME (Type): Frank M. Shipley — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-29-58
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. L. Schwab Funeral Home — ADDRESS: 2101 Frederick Ave
24a. REC'D BY REGISTRAR — DATE: SEP 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9810

CERTIFICATE OF DEATH

09797 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 20y 7m 29d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rena — Middle — Last Norwood

4. DATE OF DEATH: Month 9 — Day 11 — Year 19 58

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): ---

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ---

14. MOTHER'S MAIDEN NAME: ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure
DUE TO
(b): Pneumonia with Undetermined organism
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-10-, 19 58, to 9/11, 19 58, that I last saw the deceased alive on 9/11/, 19 58, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Konstantin Weber, M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/11/58

PHYSICIAN'S NAME (Type): K. Weber, M. D. — Crownsville State Hospital, Md. — 9/11/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 9-12-58

22c. NAME OF CEMETERY OR CREMATORY: [illegible] Md.

22d. LOCATION (City, town, or county) (State): Balto, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible], Md.

24a. REC'D BY REGISTRAR — DATE: SEP 16 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9761

CERTIFICATE OF DEATH

09798 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE Md. b COUNTY AA
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside
d STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Joseph Middle — Last Parker
4. DATE OF DEATH Month 9 Day 2 Year 1958

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 14 1886
9. AGE (In years last birthday) 72 yrs
IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberstone
12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME Isaac —
14 MOTHER'S MAIDEN NAME Catherine —

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) —
16 SOCIAL SECURITY NO.
17. INFORMANT Susanna Parker Address Shadyside Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-24-58, 19—, to 9-24-58, 19—, that I last saw the deceased alive on —, 19—, and that death occurred at —M, from the causes and on the date stated above.

ACTUAL SIGNATURE A T Allen M.D.
ADDRESS (Street, city or town, state) 61 Cathedral St Annapolis, Md.
DATE SIGNED 9-10-58
PHYSICIAN'S NAME (Type) A. T. ALLEN

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 9/5/58
22c. NAME OF CEMETERY OR CREMATORY Ebenezer
22d LOCATION (City, town, or county) Lothesville Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE Burnett Funeral Home ADDRESS Hacklett Md.
24a REC'D BY REGISTRAR DATE SEP 10 '58
24b REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9811 CERTIFICATE OF DEATH

Reg. Dist. No. 09799

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GREEN HAVEN
c. LENGTH OF STAY IN 1b: 14 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7TH STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GREEN HAVEN
d. STREET ADDRESS: 7 th STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle ANNA Last PECORARO

4. DATE OF DEATH: Month SEPT. Day 3 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 5, 1904

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: JOHN LOTZ

14. MOTHER'S MAIDEN NAME: CATHERINE CUNEO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): ////////

16. SOCIAL SECURITY NO.: None

17. INFORMANT: HUSBAND — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA LUNGS — INTERVAL BETWEEN ONSET AND DEATH: 3 MONTHS

174x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CARCINOMA UTERUS — 9 MONTHS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT. 1957, to SEPT. 3, 1958, that I last saw the deceased alive on SEPT. 1, 1958, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D. Brady Smith M.D — ADDRESS (Street, city or town, state): RIVIERA BEACH — DATE SIGNED: 9/3/58

PHYSICIAN'S NAME (Type): D. BRADY SMITH — CAPE CODENA, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 8, 1958

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: A. V. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 5 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9:55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9812 CERTIFICATE OF DEATH

Reg. Dist. No. 09800

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9 yrs. 3m
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1315 Ashland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thelma; Middle: ; Last: Penry

4. DATE OF DEATH: Month: 9; Day: 18; Year: 1958

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 1/9/02

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Penry (Deceased)

14. MOTHER'S MAIDEN NAME: Fanniie Johnson (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH:
141.9
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Carcinoma of the tongue
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, Undifferentiated Type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. ------ 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ------

21. I certify that I attended the deceased from 6/18, 1958, to 9/18, 1958, that I last saw the deceased alive on 9/18/, 1958, and that death occurred at 4:00 P.M, from the causes and on the date stated above

ACTUAL SIGNATURE: L Benedict M.D — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/18/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. — 9/18/58

22a. BURIAL, CREMATION, REMOVAL (Specify): ✓

22b. DATE THEREOF: 9.19.58

22c. NAME OF CEMETERY OR CREMATORY: U of Md. Med. School

22d. LOCATION (City, town, or county) (State): Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: #2 108 N. Westk. St. Annapolis Md

24a. REC'D BY REGISTRAR DATE: SEP 24 '58

24b. REGISTRAR'S SIGNATURE: Arthur J. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9813

CERTIFICATE OF DEATH

Reg. Dist. No. 09801

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 4 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION: CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CALVERT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DOWELL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ ?

3. NAME OF DECEASED (Type or print): First (LORIN) Middle LOWNDES Last PHILLIPS

4. DATE OF DEATH: Month 9 Day 15 Year 1958

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/14/96

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RICHARD PHILLIPS

14. MOTHER'S MAIDEN NAME: CHRISTINA WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO:

17. INFORMANT: HOSPITAL RECORDS — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH:
162.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) BRONCHO GENIC CARCINOMA
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5/8/58 to 9/15/58, that I last saw the deceased alive on 9/15/58, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/15/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. — 9/15/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 18, 1958

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph L Russ — ADDRESS: 2222 N north ave.

24a. REC'D BY REGISTRAR DATE: 9/17/58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9762 **CERTIFICATE OF DEATH** 09802

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHALK PT, MD X
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle MAY Last PHIPPS

4. DATE OF DEATH: Month SEPT. Day 4 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 23 1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CHALK PT, MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Rivchner
14. MOTHER'S MAIDEN NAME: ELIZABETH WALKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Russell E. Phipps Address: West River P.O.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 seconds

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary artery atherosclerosis — 5 yrs.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260 Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to Sept 4, 1958, that I last saw the deceased alive on Sept 4, 1958, and that death occurred at 4 00 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Ridenour M.D. ADDRESS (Street, city or town, state): 121 Cathedral St. Annapolis, Md. DATE SIGNED: 9/5/58

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 7 1958
22c. NAME OF CEMETERY OR CREMATORY: Woodfield
22d. LOCATION (City, town or county): Gaithersville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty Gaithersville Md. ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 16 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 & 17a filled in 9/20/58 mcj

9763 **CERTIFICATE OF DEATH** 09803

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marley Park- Glen Burnie
d. STREET ADDRESS: 20 Greenway Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle — Last PLEWS

4. DATE OF DEATH: Month SEPTEMBER — Day 14 — Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 22, 1886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron worker
10b. KIND OF BUSINESS OR INDUSTRY: ship yrd.
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Plews
14. MOTHER'S MAIDEN NAME: Jane (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-01-3222A
17. INFORMANT: Harriett Plews- Wife- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6/26/58
DUE TO (b): Generalized Cerebral Arteriosclerosis — 4 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had several previous attacks.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/26/58, 19, to 9/14/58, 19, that I last saw the deceased alive on 9/13/58, 19, and that death occurred at 8:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice Klawans M.D. — ADDRESS (Street, city or town, state): 31 Southgate Ave — DATE SIGNED: 9/16/58

PHYSICIAN'S NAME (Type): Maurice Klawans MD — Southgate Ave. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-17-58
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Cemetery
22d. LOCATION (City, town, or county) (State): Howard County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING AND KIRKLEY — ADDRESS: Glen Burnie, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 18 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9814 CERTIFICATE OF DEATH

Reg. Dist. No. 09805

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll Tou Manor
c. LENGTH OF STAY IN 1b 5 mo
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Severna Park md

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md b COUNTY A.A
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d STREET ADDRESS md
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Franklin Middle Jacob Last Rhodes
4. DATE OF DEATH Month 9 Day 10 Year 1958

5 SEX Mald
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Mar 13 1882
9. AGE (In years last birthday) 76 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10b KIND OF BUSINESS OR INDUSTRY Machine Shop
11. BIRTHPLACE (State or foreign country) High House Penn
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Rhodes
14 MOTHER'S MAIDEN NAME Susan Dorsey

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) U.S. Army
16 SOCIAL SECURITY NO
17 INFORMANT Daughter - Elsie M. Ziegler Address Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
443
DUE TO (b) Hypertensive C.V. Desease
DUE TO (c) Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19____, to 9-5-58, 19____, that I last saw the deceased alive on 9-3-58, 19____, and that death occurred at 7:10 p.m., from the causes and on the date stated above

ACTUAL SIGNATURE Robert R. Hahn M.D.
ADDRESS (Street, city or town, state) Severna Park md
DATE SIGNED 9-10-58

PHYSICIAN'S NAME (Type) Robert R. HAHN. Severna Park md

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/13/58
22c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping and Kirkley, Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE SEP 15 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9815 **CERTIFICATE OF DEATH** Reg. Dist. No. 09806

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie,
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: #206 Crain Highway, S.W.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d. STREET ADDRESS: #206 Crain Highway, S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GRACE — Middle REBECCA — Last RHODES

4. DATE OF DEATH: Month September — Day 3, — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 13, 1878

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Howard Co., Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Benjamin T. Ray

14. MOTHER'S MAIDEN NAME: Virginia Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ////////

16 SOCIAL SECURITY NO.: 214 22 8397

17. INFORMANT Address: Mrs. Virginia Bowers Glen Burnie, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure, Severe — INTERVAL BETWEEN ONSET AND DEATH: 3 Years

DUE TO (b): Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 19 25 to September 19 58 that I last saw the deceased alive on 9-3 19 58, and that death occurred at 6 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles R. MacDonald M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Maryland — DATE SIGNED: 9/4/58

PHYSICIAN'S NAME (Type): Charles R. MacDonald, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 6/58

22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

22d. LOCATION (City, town, or county) (State): Howard Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9816 **CERTIFICATE OF DEATH** 09807

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville RFD
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Elvaton Road - Box 149

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville, RFD
d. STREET ADDRESS: Elvaton Road - Box 149
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GROVER Middle CLEVELAND Last RILEY

4. DATE OF DEATH: Month September Day 23, Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 23, 1886

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Exp.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marion F. Riley

14. MOTHER'S MAIDEN NAME: Amelia Fine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ////////

16. SOCIAL SECURITY NO.: 714 03 4554

17. INFORMANT: Mrs. Pauline D. Riley, Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ____
DUE TO
(c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 54, to Sept. 23, 19 58 that I last saw the deceased alive on Sept. 21, 19 58, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 9-24-58

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D. Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 26/58

22c. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. P. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 26 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9817 — 09808 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena (RFD)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mayfield r Rt. Rds - Box 458 - Rt. 8

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena (RFD)
d. STREET ADDRESS: Mayfield r Rt. Rds - Box 458 - Rt. 8
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Josephine — Last: Rosemary

4. DATE OF DEATH: Month: September — Day: 15 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept 15, 1900

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aid (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Jenkins Mem. Hosp.

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John G. Gibbin

14. MOTHER'S MAIDEN NAME: Anna Knell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-14-0372

17. INFORMANT: Mrs. Ruth E. Thorley — Address: Same As #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Adeno-carcinoma pharynx — 1 year

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cachexia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 1957 to Sept 15, 1958, that I last saw the deceased alive on Sept 13, 1958, and that death occurred at 4 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Lankford Jr M.D. — ADDRESS (Street, city or town, state): Mountain Rd Pasadena Md — DATE SIGNED: 9/16/58

PHYSICIAN'S NAME (Type): ARTHUR LANKFORD JR PASADENA MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 18, 1958

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. V. Leighton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: SEP 18 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Items 2 &20 Film 2[illegible]
5104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09809

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sylvan Shores Annapolis
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: ~~Anne Arundel~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Sylvan Shores~~ Takoma Park
d. STREET ADDRESS: 813 Davis
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cameron — Middle M. — Last Ross III
4. DATE OF DEATH: Month Sept — Day 7 — Year 1958
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 29 1954
9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bethesda, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Cameron M Ross, Jr
14. MOTHER'S MAIDEN NAME: Charlotte May ~~Deuchalm~~ Duchalm
15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Cameron M. Ross, Sr. — Address: 813 Davis Ave T.P. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 929.8
DUE TO (b): Drowning
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowning - Fell from dock into river
20c. TIME OF INJURY: Hour 3 a.m. p.m. — Month, Day, Year: Sept 7 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River
20f. (City or town): Slyvan Shores — (County): A.A. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I Hudson Jr M.D.
EXAMINER'S NAME (Type): James I. Hudson, Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: Sept 7, '58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT 10 1958
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George Co. Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters — ADDRESS: Wash D.C. 254 Carroll St NW
24a. REC'D BY REGISTRAR DATE: SEP 11 58
24b. REGISTRAR'S SIGNATURE: Clifton L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09810

9765

1. PLACE OF DEATH
a. COUNTY A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AA General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY AAco
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
d. STREET ADDRESS Thelma Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Agnes Last Schaeck
4. DATE OF DEATH Month 9 Day 22 Year 19 58
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 20, 1892
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Mack
14. MOTHER'S MAIDEN NAME Elizabeth Shade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. -----
17. INFORMANT Address Mr. John Scherer, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D.
EXAMINER'S NAME (Type) E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9.22.58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/25/58
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial
22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE James A. Kirkley ADDRESS Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE SEP 24 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9818 — Reg. Dist. No. 09811

1. PLACE OF DEATH — a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Epping Forest
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis R7D

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Epping Forest
d. STREET ADDRESS: Annapolis R7D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oliver — Middle: M. — Last: Schneider
4. DATE OF DEATH: Month: Sept — Day: 20 — Year: 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-7-1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. U.S.M.C.
10b. KIND OF BUSINESS OR INDUSTRY: U.S Marine
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Schneider
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): I and II
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Helen Clair Schneider (2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1 × Gun Shot wound Skull — INTERVAL BETWEEN ONSET AND DEATH: Instan
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): self inflicted gun shot wound
20c. TIME OF INJURY — Hour: p. m. — Month, Day, Year: 9/20/58
20d. INJURY OCCURRED — While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 9/20/58
EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 23-58
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county): Arlington (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Gaylor Sons Annapolis Md
24a. REC'D BY REGISTRAR — DATE: SEP 23 '58
24b. REGISTRAR'S SIGNATURE: [illegible] S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: [illegible]

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9819 **CERTIFICATE OF DEATH** 09812

Reg. Dist. No.

1. PLACE OF DEATH
a COUNTY A.A. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
c LENGTH OF STAY IN 1b 71
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Grove Rd.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE
b COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glenn
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print) First Paul Middle Rudolph Last Schultz

4. DATE OF DEATH Month Sept. Day 30 Year 1958

5 SEX M

6. COLOR OR RACE W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH Aug 12 1874

9 AGE (In years last birthday) 84 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - (ret'd)

10b KIND OF BUSINESS OR INDUSTRY Own Farm

11 BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY U S A

13. FATHER'S NAME Wm Schultz

14 MOTHER'S MAIDEN NAME Wilhelmina >

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16 SOCIAL SECURITY NO None

17. INFORMANT Anna Walters Address Severn

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs.

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1958, to 9/30, 1958, that I last saw the deceased alive on 9/30, 1958, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Chas. L. Ball Jr. M.D. ADDRESS (Street, city or town, state) 203 W. Maple Rd - Linthicum Md. DATE SIGNED 9/30/58

PHYSICIAN'S NAME (Type) Chas - L. Ball, Jr.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 4 1958

22c NAME OF CEMETERY OR CREMATORY Glen Haven Cem.

22d. LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE T. V. Singleton ADDRESS Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE OCT 6 '58

24b. REGISTRAR'S SIGNATURE C. Hall S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9820 **CERTIFICATE OF DEATH** Reg. Dist. No. 09813

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4y 2m 1d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James — Middle — Last Simms

4. DATE OF DEATH: Month 9 — Day 22 — Year 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1882

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): ----------

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ***----------

14. MOTHER'S MAIDEN NAME: ----------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 12/12/18

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cancer of stomach
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ----------

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ---------- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 7/21, 19 54, to 9/22, 19 58, that I last saw the deceased alive on 9/22, 19 58, and that death occurred at 3:04 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 9/23/58

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital Md. — 9/23/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/25/58

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: R. L. SNOWDEN Rockville Md.

24a. RECD BY REGISTRAR DATE: SEP 26 58

24b. REGISTRAR'S SIGNATURE: Arth. S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)
1SM 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03814

Reg. Dist. No. 9821

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 45 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel Race Track

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — COUNTY: Howard County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: North Laurel Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Smith
4. DATE OF DEATH: Month: 9/28/58 — Day — Year: 19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
M	C		1/27/04	yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Race Horses Care Taker.		Virginia.	USA

13. FATHER'S NAME: ? SIDNEY SMITH
14. MOTHER'S MAIDEN NAME: ? Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No			Mrs. Dorothy Mae Smith (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19	20d. INJURY OCCURRED: While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave F. Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave F. Faubert, M.D. — 9/29/58

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	10/2/58	Snells Cemetery	Near Laurel	Md

23. FUNERAL DIRECTOR'S SIGNATURE: R. Digby Selby — ADDRESS: 401 High and Laurel Md

24a. RECD BY REGISTRAR — DATE: OCT 3 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9822

CERTIFICATE OF DEATH

Reg. Dist. No. 09815

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): GLEN BURNIE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RITCHIE HIGHWAY

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x GLEN BURNIE
d. STREET ADDRESS: RITCHIE HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First OLIVIA Middle CORDELIA Last SMITH

4. DATE OF DEATH: Month SEPTEMBER Day 5 Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 5, 1865
9. AGE (In years last birthday): 93 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND,
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: JOHN TUBBS
14. MOTHER'S MAIDEN NAME: OLIVIA ANNE STEWART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mazie S. Stoll Address: 1404 Crain Hgw. GLEN BURNIE, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1946, to Sept 5, 1958, that I last saw the deceased alive on Sept 5, 1958, and that death occurred at 1:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: James S. Bellinger M.D. ADDRESS (Street, city or town, state): 108 Central Ave. DATE SIGNED:
PHYSICIAN'S NAME (Type): James S. Bellinger Glen Burnie Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/8/58
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL
22d. LOCATION (City, town, or county) (State): BROOKLYN, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: JOHN O. MITCHELL & SONS 1900 EUTAW PL.
24a. REC'D BY REGISTRAR DATE: SEP 9 '58
24b. REGISTRAR'S SIGNATURE: Clifton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

M

I

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09816

Reg. Dist. No. 9766

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold
c. LENGTH OF STAY IN 1b Annapolis
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. A.A. General Hosp
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold, R. D.

3. NAME OF DECEASED (Type or print) First Cora Middle Lost Tucker

4. DATE OF DEATH Month 9 Day 30 Year 1958

5. SEX Female
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 2-22-1897
9. AGE (In years last birthday) 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) St. Margarets, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Isaac Stansbury
14. MOTHER'S MAIDEN NAME Emmie Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-32-5048
17. INFORMANT James Tucker Address Arnold, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4344
DUE TO (b) Cardiac disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour ~~a.m.~~ p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E Linhardt M.D.
EXAMINER'S NAME (Type) E Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 9/30/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-5-58
22c. NAME OF CEMETERY OR CREMATORY Broad Neck
22d. LOCATION (City, town, or county) Skidmore (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Fleet II
ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE OCT 2 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9823 — Reg. Dist. No. — 09817

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HEROLD HARBOR
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X HEROLD HARBOR
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle M. — Last WHITE
4. DATE OF DEATH: Month 9 — Day 14 — Year 1958
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-11-1896
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: Motel
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES M. WHITE
14. MOTHER'S MAIDEN NAME: MARY WHEATLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): WW I + II
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. JAMES BENNETT — Address: MARLEY PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9/16/58

EXAMINER'S NAME (Type): F. FINHARDT

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9-22-58
22c. NAME OF CEMETERY OR CREMATORY: Balto. National
22d. LOCATION (City, town, or county): BALTIMORE (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: SEP 22 '58
24b. REGISTRAR'S SIGNATURE: Emma L. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Page 6, burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

Item 20 Film 255 9-18-58 APB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09818

9767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore.
d. STREET ADDRESS: 2501 ALLENDALE Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: HENRY Last: Williams Sr
4. DATE OF DEATH: Month: September Day: 12 Year: 1958
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 5 1899
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest
10b. KIND OF BUSINESS OR INDUSTRY: Newspapers
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William H. Williams
14. MOTHER'S MAIDEN NAME: Bessie Goodman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Gordon Williams Address: 10449 Knollwood Drive Adelphia, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia
850X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Drowning
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in water from Boat
20c. TIME OF INJURY Hour: a.m. / p.m.: 5:00 Month, Day, Year: 8/12 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Water
20f. (City or town): Back Creek (County): A A (State): Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 9/13/58
EXAMINER'S NAME (Type): CHARLES S PETTY

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 9/16/58
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN
22d. LOCATION (City, town, or county): COLMAR MANOR (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Francis Leach Sons. ADDRESS: Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained by your office.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 234 10-10-58 ams

09819

9824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: 2 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Evergreen Trail.

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Md.
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park Md.
d. STREET ADDRESS: Evergreen Trail
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Melissa Middle Scott Last Windsor.

4. DATE OF DEATH: Month 9 Day 24 Year 1958.

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 27 July 1958

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months 1 Days 59
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore (City)

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Lloyd Eugene Windsor

14. MOTHER'S MAIDEN NAME: Jeanne Rose Snyder.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Address: Jeanne R. Windsor.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration (Accidental)
DUE TO (b): Vomiting
DUE TO (c):

921.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) A.A. (State)

21. I certify that I attended the deceased from July, 1958, to 9-24-58, 19____, that I last saw the deceased alive on Sept 25, 1958, and that death occurred at 9:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert R. Hahn M.D.
ADDRESS (Street, city or town, state): Severna Park
DATE SIGNED: 9-24-58

PHYSICIAN'S NAME (Type): Robert R. HAHN Severna Park md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-26-58
22c. NAME OF CEMETERY OR CREMATORY: Sherbert Cemetery
22d. LOCATION (City, town, or county) (State): Deale Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son
ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: SEP 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

038293XVH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9825

CERTIFICATE OF DEATH

09820

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G Meade
c. LENGTH OF STAY IN 1b: 2hrs 3 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 13 X - 2
d. STREET ADDRESS: Horseshoe Motor Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Michael — Last: Yaggi

4. DATE OF DEATH: Month: September — Day: 16 — Year: 1958

5. SEX: Male — 6. COLOR OR RACE: Cau-Mong — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 16 September 58 — 9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 2, Min. 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ronald Lee Yaggi — 14. MOTHER'S MAIDEN NAME: Kazuko Miyagi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO. — 17. INFORMANT Father: Ronald Lee Address: Yaggi, Horseshoe Mtr Court, Laurel, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 Sept 58, 19___, to 17 Sept, 19 58, that I last saw the deceased alive on 16 Sept, 19 58, and that death occurred at 0048 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U.S. Army Hospital, Ft Meade, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): MYRON J. MYERS, MD,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept 18/58 — 22c. NAME OF CEMETERY OR CREMATORY: St. Marys — 22d. LOCATION (City, town, or county) (State): Laurel Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgely Selby — ADDRESS: 401 Washington Laurel Md — 24a. RECD BY REGISTRAR DATE: SEP 19 58 — 24b. REGISTRAR'S SIGNATURE: Dalton L. Frank

2050252XVD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9826

CERTIFICATE OF DEATH

09821
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. Co.
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A. Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hill Beach
c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hill Beach, Pasadena, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Creek Drive
d. STREET ADDRESS: Creek Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Curtis Middle Franklin Last Young
4. DATE OF DEATH: Month Sept. Day 20, Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 1, 1894
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer
10b. KIND OF BUSINESS OR INDUSTRY: American Wiping Cloth Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Joseph Young
14. MOTHER'S MAIDEN NAME: Bertha E. ------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Alfred T. Sank, Creek Drive, Rock Hill Beac

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the rectum — INTERVAL BETWEEN ONSET AND DEATH: 6 years

154X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac decompensation - 2 years -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 15 19 58 to September 20, 19 58 that I last saw the deceased alive on September 20, 19 58, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. ADDRESS (Street, city or town, state): 1205 Bryn Broadway Md. DATE SIGNED: Sept 20 1958

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 24/58
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge
22d. LOCATION (City, town, or county) (State): Dorsey, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Witzke Funeral Directors, 4101 Edmondson Ave.

24a. REC'D BY REGISTRAR DATE: SEP 24 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55